Avera Health

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3900 West Avera Drive
Sioux Falls, South Dakota 57108-5721
(605) 322-4700
Fax: (605) 322-4799
www.avera.org

February 11, 2004

Commission's Secretary
Office of the Secretary
Federal Communications Commission
455 12th Street SW
Washington, DC 20554

RE: Comments on November 17, 2003 "Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60

"Consistent with section 151's mandate, further utilization of the rural health care universal service support mechanism may benefit the development of a broader and more fully integrated network of health care providers across our nation. In the aftermath of recent national events, the importance of such a network cannot be underestimated."

Avera Health is a regional non-profit healthcare delivery network that operates in over 130 communities in South Dakota, Minnesota, Iowa, Nebraska and North Dakota. Support from the Universal Service Fund has had a very positive effect on our network and has allowed us to expand and provide many services to our affiliates, such as teleradiology, telehealth, distance education, Internet-based education, Internet access, no- or low-cost internal communications, low-cost external communications, secure transaction methods, access to clinical and financial data systems as well as more effectively manage and increase efficiency in our facilities. Our private network allows us to communicate when needed and allows us to provide crucial support to rural hospitals, clinics and nursing homes that were and are struggling financially.

The Rural Health Care (RHC) support mechanism has driven down the costs of our communications network by over 60% for our RHC supported hospitals and clinics and provides support to 43 of our locations. We have participated in the program since its inception in 1998. We are very appreciative of this support and of the modifications to the program over the last five years. The program has provided approximately $1.1 million support to our rural healthcare providers through June 30, 2003. We estimate that it will provide approximately $430,000 in support to our facilities for the current funding year of July 1, 2003 to June 30, 2004.

Please review our comments below as they relate to the November 19, 2003 "Report and Order, Order on Reconsideration, and Notice of Proposed Rulemaking", WC Docket No. 02-60.

Respectfully submitted,

Jason C. Wulf
Financial Analyst

CC: Sen. Tom Daschle, (D-SD)
Sen. Tim Johnson, (D-SD)
American Hospital Association

Page 33 Section 63 & 64

It is our position that the current method utilized to determine rural and urban areas is adequate. The current method only precludes one of our organizations from participating in the program.

However, if a change is desired, we support grandfathering in existing areas that currently qualify as rural. Depending on the interpretation of the aforementioned OHRP RUCA codes, it appears from the RUCA information found at http://www.fammed.washington.edu/wwamirhrc/rucas/rucas.html , that three of our areas could potentially become classified as urban in which case we would lose a combined total of $122,500 in funding and would most likely be forced to scale our bandwidth down to a less expensive level, which would put a significant strain on telehealth applications and clinical and financial data systems. The very worst-case scenario is that we may be forced to eliminate our telehealth programs as the bandwidth expense would become cost prohibitive; and, if we reverted back to ISDN based telehealth applications, the long-distance charges incurred would also be cost prohibitive.

Another possible definition of rural is the definition provided by the Census Bureau. Under this definition, the Urban Area definition would have little impact on our healthcare organization's ability to participate; however, if urban areas are defined using the Urban Cluster definition, 17 of our 45 Rural Health Care participating organizations would lose support reducing our total from $429,000 (dollars that go directly back to patient care) to $110,000. We would lose $319,000 in support.

We feel that the Schools and Libraries Division and Rural Health Care Division should utilize the same definition of rural as currently stated in footnote 209 on page 33 of the Report and Order. An examination of the funding commitments for the Schools and Libraries program indicates that organizations within Sioux Falls, SD, an area not eligible to participate in the Rural Health Care program, are receiving funding under the Schools and Libraries program. Additionally, a search for funding commitment in the Minneapolis, MN area, population 3.02 million (http://www.twincityscape.com/demographics.html accessed 12-4-03), versus Sioux Falls, SD population of 172,412 (http://minneapolisfed.org/pubs/fedgaz/01-09/metro.cfm accessed 12-4-03), yielded commitments of $3.8 million (http://www.sl.universalservice.org/funding/ accessed 12-4-03). Healthcare providers in both of these areas are not eligible for any kind of support under the Rural Health Care program. It seems that there is some disparity in funding decisions as organizations in urban areas receive funding under the Schools and Libraries program, while healthcare providers in urban areas do not receive support under the Rural Health Care program.

The current funding cap for the RHCD program is $400 million, however, according to the RHCD website, as of January 21, 2004 only $23.3 million has been committed for Funding Year 2002 and only $19.7 million was committed for Funding Year 2001. According to the American Hospital Association, there are currently 5,794 registered hospitals in the U.S. of which 2,178 are rural (http://www.hospitalconnect.com/aha/resource_center/fastfacts/fast_facts_US_hospitals.html accessed 1-21-04). If urban hospitals were allowed to participate, as urban schools

and libraries are in the Schools and Libraries program, the average support amount per hospital would be approximately $69,037 ($400,000,000/5,794 total hospitals). Currently, the average support amount **available** for each rural hospital is $183,654 ($400,000,000/2,178 rural hospitals), assuming they are all not-for-profit. The actual number of participants in Funding Year 2001 (excluding Alaska providers) was 1,049 at an average of $6,340 per provider and in Funding Year 2002 the numbers rose slightly to 1,210 providers at an average of $7,508 per provider. Alaska accounted for 145 providers in Funding Year 2001 and 164 in 2002 at an average of $89,917 and $80,749 respectively. Therefore, the inclusion of the 3,616 hospitals that are currently ineligible to participate in the program would greatly increase participation in the program and would push the actual amount of funding closer to the cap, though not likely over the amount of the cap.

While this analysis does not take into consideration other types of eligible applicants, according to a presentation made by USAC at the OAT Telemedicine conference in January 2004, only a small percentage of non-hospital or non-clinic providers participated in the program.

To summarize, we support updating the definition of rural so long as it is not detrimental to current participants. The RHC program and Schools and Libraries program could be made more functionally similar so that the RHC program could offer discounts to urban hospitals as the Schools and Libraries program does to urban schools and libraries without going over the $400 million cap. We realize that Congress will need to make that determination, but felt it was an important point to bring to light.

Pages 34 – 35 Section 65 – 68

Mobile health clinics should only be supported for the percentage of time that they are serving rural areas. For example, if the mobile unit serves an urban location (not just parked, but actually providing services) for four out of 52 weeks, the support should be reduced by approximately 8%. If it serves an urban location 26 out of 52 weeks, the support should be reduced by 50%.

The most equitable basis for comparison in the instance of satellite data services will likely be the comparison of data rates, i.e., 1.5mb synchronous satellite service compared to 1.5mb synchronous wireline service. It would be logical to use the categories set forth in the November 2003 Report and Order on page 19, section 34. Thus, if a 1.5mb satellite connection costs approximately $10,000 per month and the urban rate for a 1.5mb wireline connection is $360.04 per month, the RHC applicant would receive $9,639.96 in support monthly ($115,679.52 annually). While this is a significant amount of funding for one provider, it will not greatly impact the $400 million cap.

While wireline services have an established Maximum Allowable Distance (MAD), satellite services are not distance based and can conceivably connect anywhere in the nation or world. This does present the mobile clinic with an advantage as it can connect with whomever it chooses and not incur a penalty in the form of reduced support as a result. Fixed location providers are potentially disadvantaged by this limitation. Since the Commission declined to eliminate the MAD, page 22, section 41 of the Report and Order, some limitation should be placed on the satellite service. For example, if the distance from the largest urban location is 500 miles to the furthest rural city in the state, the mobile provider should incur a reduction in support for connections over that

distance. The distance from the nearest rural point that the mobile unit visits to the site where the data or images are ultimately read could be used to determine the distance of the connection. A potential calculation could use the percentage difference. For example, if the distance between the satellite transmitter and satellite receiver is 1,000 miles and the longest MAD for the state is 500 miles, the support would be cut by fifty percent. However, the challenge of determining an equitable calculation could be avoided through the elimination of the MAD.

It would be reasonable to require the mobile provider to demonstrate through network maps and corresponding quotes that the satellite services are more cost effective than wireline services. For example, if a T1 connection from a rural site that the mobile provider serves to its corresponding urban site costs $1,000 and the mobile provider serves only eight such sites, this would be more cost-effective than one $10,000 satellite connection. However, the provider would likely incur a much higher net cost as it would have to add all eight urban rates together to arrive at its net cost versus only one urban rate for the satellite connection. Additionally, the provider may incur higher equipment and network management costs due to having multiple connections. While maintaining separate connections may prove more cost-effective for the RHC, it may not be nearly as efficient for the mobile health care provider.

In short, we are in favor of providing support for satellite services; however, certain requirements and limitations should be established to limit the possibility for abuse. A mobile healthcare venture such as the one described in the Report and Order will provide a valuable service and improve the health of rural citizens.

Page 35 – 36 Section 69

The Rural Health Care Division (RHCD) has done a wonderful job of streamlining the application process. However, there are some things that could further streamline the process and improve communication with applicants.

Allowing applicants the option to submit documentation (such as copies of contracts, bills, or urban rates) electronically will greatly enhance the application process. This could be accomplished by one of two methods. Applicants would scan the documents and convert them to a .pdf format in both instances and either e-mail them to the RHCD to a specific e-mail address or upload the documentation through the applicant's login page on the website. This would allow the documentation to be automatically entered into the database as part of the applicant's record. Applicants can obtain scanners relatively inexpensively (less than $100) and .pdf creation software can be obtained for approximately $50 (or even free through websites such as www.pdf995.com).

A possible method to increase communication would be to modify the website so that when applicants login, it would not only show which electronic forms have been posted as it currently does, but it could also show which paper documents have been received and the dates they were received. I recently checked the packet status report posted on the RHCD website and it listed seven of our organizations as needing documentation or clarification. I called the RHCD help line to determine what items were needed, but all items had arrived and nothing was needed. The packet status report is currently only posted at the end of the month, but this method would provide "real-time" access to the information.

One additional change in communication could further increase efficiency and potentially reduce administrative costs for the program. Currently, correspondence from the RHCD is mailed to the health care provider's contact person. When sent by regular mail, items such as Funding Commitment Letters and Support Schedules may be delayed by several days, which further delays funding to the Health Care Provider (HCP). The RHCD could generate all correspondence electronically in .pdf format at little cost ($0 to $50 one-time cost for each person generating letters, mailers, etc) and e-mail the documents the same day they are generated. This process has the potential to eliminate up to two weeks of "wait time" for the HCP's as well as reduce the RHC's printing and mailing costs.

These comments represent the following Avera Health organizations that participate in the Universal Service/Rural Health Care Division program:

Avera Flandreau Hospital	Flandreau, SD
Avera Holy Family	Estherville, IA
Avera Queen of Peace	Mitchell, SD
Avera Sacred Heart	Yankton, SD
Avera Selby Clinic	Selby, SD
Avera St. Anthony's Hospital	O'Neill, NE
Avera St. Benedict	Parkston, SD
Avera St. Luke's	Aberdeen, SD
Avera United Clinic	Ellendale, ND
Avera Weskota Hospital	Wessington Springs, SD
Bon Homme Family Practice	Tyndall, SD
Eureka Community Hospital/Avera Health	Eureka, SD
Floyd Valley Hospital/Avera Health	LeMars, IA
Fulda Clinic/Avera Health	Fulda, MN
Gregory Healthcare Center/Avera Health	Gregory, SD
Hand Co. Memorial Hospital/Avera Health	Miller, SD
Hegg Memorial Health Center/Avera Health	Rock Vally, IA
Landmann-Jungman Memorial Hospital/Avera Health	Scotland, SD
Larchwood Medical Clinic/Avera Health	Larchwood, IA
Marshall Co. Clinic/Avera Health	Britton, SD
Marshall Co. Hospital/Avera Health	Britton, SD
Milbank Medical Clinic/Avera Health	Milbank, SD
Avera Milbank Hospital	Milbank, SD
Mobridge Family Practice/Avera Health	Mobridge, SD
United Medical Clinic/Avera Health	Windom, MN
Pipestone Co. Medical Group	Pipestone, MN
Platte Health Center/Avera Health	Platte, SD
Rosebud Family Clinic/Avera Health	Gregory, SD
Schramm Medical Clinic/Avera Health	Winner, SD
Sioux Center Community Hospital/Avera Health	Sioux Center, IA
Sioux Center Hull PT and Sports Rehab Clinic/Avera Health	Hull, IA
Southwestern Mental Health Center, Luverne	Luverne, MN
Southwestern Mental Health Center, Worthington	Worthington, MN
Southwestern Mental Health Center, Windom	Windom, MN

Southwestern Mental Health Center, Pipestone	Pipestone, MN
Spencer Family Clinic/Avera Health	Spencer, IA
Spirit Lake Medical Center/Avera Health	Spirit Lake
Waubay Clinic/Avera Health	Waubay, SD
Wagner Community Memorial Hospital	Wagner, SD
Worthington Specialty Clinics/Avera Health	Worthington, MN